STATEMENT OF CHIEF WARRANT OFFICER RODGER L. SHUTTLEWORTH

CHIEF, RESERVE COMPONENT PERSONNEL SUPPORT SERVICES BRANCH,

U. S. ARMY HUMAN RESOURCES COMMAND

BEFORE THE COMMITTEE ON GOVERNMENT REFORM

UNITED STATES HOUSE OF REPRESENTATIVES

HEARING

"WOUNDED ARMY GUARD AND RESERVE FORCES: INCREASING THE CAPACITY TO CARE"

THURSDAY, FEBRUARY 17, 2005

Mr. Chairman and Members of the Committee, it is a distinct honor to be here to discuss important issues affecting injured Reserve Component soldiers including those injured as a result of the Global War on Terrorism. Our Reserve Component soldiers have bore the brunt of growing pains necessary to change a system that was not designed to support Reserve Component soldiers.

My name is Chief Warrant Officer Rodger Shuttleworth. My military career began in 1973 where I served in the active Army until 1981. I then joined the Maryland Army National Guard and became a full time employee with the National Guard Bureau in 1988. I was assigned to my current position as Chief of the Reserve Component Support Services Branch, Army Human Resources Command in February 2000. My responsibilities include all aspects of personnel issues for Reserve Component soldiers ordered to active duty under Title 10, but not all active Guard and Reserve issues.

Prior to September 11, 2001, there were only two programs that dealt with injured reserve component soldiers, ADME and Incapacitation Pay. Incapacitation pay and allowances are paid without a soldier being ordered to active duty. There are a lot of soldiers on incapacitation pay, over $3 million monthly is spent on their care and without proper oversight, questions on the best use of this money remains. If these soldiers were placed on ADME, they would be better managed and the Army would spend less money on getting them returned to duty or entered into the Physical Disability System.

The numbers of injured RC soldiers in these programs prior to 2001 were manageable, but due to the largest mobilization of Guard and Reserve since WWII in the Global War on Terrorism, the amount of injured needing assistance and help grew beyond our capacity to assist.

For example, I started with a staff of six. At that time, the Adjutant General of the Army gave me a mission to do all I could to increase our capacity to care for injured Reserve Component Soldiers. At this time, the only process to help injured Guard and Reserve was Active Duty Medical Extension (ADME) and incapacitation pay. ADME, prior to September 11, 2001, was only used to order drilling reservists injured in the line of duty during training to active duty for medical care. Because we were not prepared and the disaster on 9/11, ADME has to be used to support GWOT soldiers injured in the line of duty. Because ADME was not specifically designed for the GWOT, soldiers were being denied eligibility, fell off the pay system and lost benefits for their families. ADME was supposed to last 179 days, longer than the 30 days given, but the Army G-1, who was responsible for to establishing and interpreting ADME policy, also chose to execute it and they became a major stumbling block, shortening extensions, as we tried to insure GWOT soldiers were treated equally to their active duty counterparts.

These problems continued until the creation of Medical Retention Process (MRP)in March 2003. This was an improvement better because the application process was easier, the requirements were streamlined, all extensions were now automatically 179 days, and we also directly submit soldiers orders to Defense Finance and Accounting Service so problems with pay and benefits will end. In January 2004, I established the Medical Services Section of my branch to facilitate MRP processing, medical board processing, and other RC personnel system for medical reasons. During this time, we began to realize we were also responsible to train and assist Reserve Component and active Army personnel in medical care facilities who had any questions at all on reserve component processing. Some calls are from medical holdover companies who do not always know how to process or help the Reserve and Guard being treated at their facilities. But most of our callers are Guard and Reserve soldiers who have not gotten answers from their chain of command or command at their facilities, and have exhausted all other avenues of help and service.

One of the major problems is that Army medical personnel do not interface with Army personnel specialists, and this continues to cause serious misunderstanding, delays and holdups in personnel services. Another of the major problems we have is that Medical Command personnel tell injured Guard and Reserve one thing, and we tell them another.

Another continuing source of inter- Army command difficulties for us involve our relationship with Army G-1. Army G-1 is by definition supposed to be a source of policy decisions and innovation, and we at Army Human Resources Command are the executors, but it hasn't always been the case. This causes the following problems: great delays in approval on each soldier's paperwork causing increased stays in treatment, pay problems, benefits and great family stress. We have spent far too much time debating between our offices on the most effective way to support injured Reserve Component soldiers. In regard to our difficulties, I am happy to report that two days ago, Army G-1 transfered functionally responsibility for all types of reserve component personnel management with regard to medical readiness processing to my branch.

I want to bring forward another problem that my staff and I encounter every day. Reserve Component soldiers are remaining on Active Duty for long periods of time without being entered into the Physical Disability Process and remain in the Medical Board Process for long periods of time. Of the paperwork we review, approximately 80% of ADME and MRP Reserve Component soldiers end up in the Physical Disability System. Part of the problem is a shortage of trained manpower at both Medical Command and the US Army Physical Disability Agency. Injured Reserve Component soldiers have paid the price for this, but we are trying to improve manning and training.

Guard and Reserve soldiers have so many difficulties because the active Army tries to treat them like active Army soldiers in all cases, and in some instances you cannot.

An example is, when an active army soldier is medi-vaced from a theater of operation to a stateside medical facility and is determined to be an outpatient, they are returned to their home unit for their period of recovery. A Reserve Component soldier may not have a home station because his unit has been mobilized, and there may be no one left at the home station to assist them. This causes us to lose accountability for these soldiers. All of them are authorized to receive medical care and treatment, and should be reported through an active Army organization prior to returning to their home of record. To alleviate this problem, the Army has created the Community Based Health Care Initiative (CBHCI). This initiative will allow some injured Reserve Component soldiers, after being processed through an active Army organization, to return to their home of record and their families, remain on active duty and receive medical care. Each Community Based Health Care Organization is responsible for the care and accountability of soldiers assigned them. My office assists in training the staff and personnel in these newly created facilities. In addition to that, I have placed over 80 NCO's at Army treatment facilities in the United States and Germany to assist in patient tracking and medical board processing. Because of the placement of these NCO's, completed Medical Boards ratios have improved…..now over 400 are being done annually. I have also placed personnel in the US Army Physical Disability Agency, DOD's Defense Finance and Accounting Service and at the CBHCOs. We were also asked very recently by the Army Installation Management Agency to provide experienced Reserve Component command and control staff on site in installations because there is a shortage of permanent staff at installation Medical Readiness Processing units and CBHCOs. There is still a need to sustain this staff currently and at least 2 years after current contingency operations end. As of last week, the Director of the Army Staff has approved my office to fill this leadership void through the Army-Extended Active Duty program.

I hope from my testimony, you understand how important it is to me and my staff that the Army continues to resource and improve policies aimed at supporting injured Guard and Reserve soldiers.

There are four things I want to bring to your attention:

One involves a needed change in Title 10. Under current law, Reserve Component soldiers not injured in the line of duty are entitled to a retirement benefit that soldiers who are injured in the line of duty are not entitled too, and that bothers all of us. I respectfully ask that Congress change this unfair law. Right now, if you are injured prior to entering into the armed forces and have 15 years of credible reserve service, and are found to be non-retainable, you are eligible to retire and obtain benefits at age 60. But if you agree to come to active duty and fight for your country, and are injured in the line of duty, you are not entitled to this benefit. The Law is Title 10, Subtitle E, Part II, Chapter 1223, Section 12731b.

Secondly, I have deep concerns about current Army procedures for injured Reserve Component soldiers at certain Army installations including Walter Reed Medical Center, Fort Bragg, Fort Bliss, Fort Lewis, Fort Dix and Fort Drum.

These installations do not provide timely or accurate medical personnel records or line duty investigations that are vital to the reserve component soldiers who are leaving active duty and will need future medical care. At these installations, there is no standard or consistency in who is responsible for providing us timely and accurate records or applications for MRP extensions so that a soldier is entered in the system. If this doesn't change, Army case managers will not have access to records they need, orders will be cut too late, and pay and benefits will be affected. I ask the Army Installation Management Agency to help create standards for installations so that we all have the same policies to in place to assist these soldiers.

Thirdly, even with the new influx of medical caseworkers assigned to assist injured reserve and guard, the ratio between patient and care manager is still too high at 50 to 1 at each hospital, and now 30 to 1 at each CBHO. These people are crucial to making appointments, liaising with families, liaising with doctors on treatment timetables

and also entering correct information into MODS, one of the many databases tracking medical data, timely and accurately. If you can, please help us with this.

Lastly, my office needs more resources. I have space issues, funding issues to visit facilities for training and assistance, and equipment shortages. I have time and again requested from my budget office the ability to use reimbursable GWOT funds to cover these expenses and am denied and I don't understand the reluctant to use already dedicated funds. I look Congress to consider line item appropriations to help us help the Reserve and Guard.